

WISCONSIN MEDICAID  
MANAGED CARE PROGRAM PROVIDER APPEAL

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services. The use of this form is voluntary.

Providers may send this completed form and other written complaints to:

Wisconsin Medicaid  
Managed Care Appeals  
PO Box 309  
Madison WI 53701-0309

INSTRUCTIONS: Type or print clearly.

SECTION I — PROVIDER INFORMATION		
Name — Provider Filing Appeal	Telephone Number — Provider Filing Appeal	Name — HMO / SSI MCO Involved
Address — Provider Filing Appeal (Street, City, State, Zip Code)		Name and Telephone Number — Contact Person
SECTION II — ENROLLEE INFORMATION		
Name — Medicaid HMO / SSI MCO Enrollee	Medicaid Identification Number	Date of Service

SECTION III — DESCRIPTION OF PROBLEM		
Describe the problem in detail. Use additional paper, if necessary. Attach copies of any supporting documentation relevant to the problem.		

SECTION III — DESCRIPTION OF PROBLEM (Continued)

Insert date the appeal was sent to HMO / SSI MCO or claim reconsideration was requested.	Insert date the appeal / reconsideration request was denied by HMO / SSI MCO.
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What response was received from the HMO / SSI MCO? Attach a photocopy of any relevant correspondence.

What does the provider consider to be a fair resolution of this matter?

SECTION IV — SIGNATURE

This information is accurate to the best of my knowledge. A copy of this information may be forwarded to the Medicaid HMO/SSI MCO involved.	
SIGNATURE — Provider	Date Signed